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DENNIS E. DOELLE, D.D.S.

MEDICAL HEALTH UPDATE

Patient Name: _____

The following information will not be released without written permission.

Do you have, or have had any of the following? Please mark any that apply.

	YES	NO
Heart Problems	☐	☐
Chest Pain	☐	☐
Shortness of Breath	☐	☐
Blood Pressure Problems	☐	☐
Heart Murmur	☐	☐
Heart Valve Problem	☐	☐
Taking Heart Medication	☐	☐
Rheumatic Fever	☐	☐
Pacemaker	☐	☐
Artificial Heart Valve	☐	☐
Blood Problems	☐	☐
Easy Bruising	☐	☐
Frequent Nosebleeds	☐	☐
Abnormal Bleeding	☐	☐
Blood Disease (Anemia)	☐	☐
Ever require a Blood Transfusion?	☐	☐
Allergy Problems	☐	☐
Hay Fever	☐	☐
Sinus Problems	☐	☐
Skin Rashes	☐	☐

	YES	NO
Allergy Problems (cont.)	☐	☐
Taking Allergy Medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight Gain or Loss	☐	☐
Special Diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or Bladder Problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or Neck Pain	☐	☐
Joint Replacement	☐	☐
Fainting Spells	☐	☐
Seizures	☐	☐
Epilepsy	☐	☐
Frequent or Severe Headaches	☐	☐
Thyroid Problems	☐	☐
Cancer/Tumor	☐	☐

	YES	NO
Diabetes	☐	☐
Urinate more than 6 Times a Day	☐	☐
Thirsty or Mouth Dry Much of the Time	☐	☐
Family History of Diabetes	☐	☐
Tuberculosis or other Respiratory Disease	☐	☐
Hepatitis A,B,C or Liver Trouble	☐	☐
HIV-Positive/AIDS	☐	☐
Herpes or other STD	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you drink alcohol?	☐	☐
If so, how frequently? _____		
Do you smoke?	☐	☐
If so, how frequently? _____		
Persistent Cough or Swollen Glands	☐	☐
Premedications Required by Physician	☐	☐

Are you allergic, or reacted adversely to any of the following?

	YES	NO
Local Anesthetics (“Novocaine”)	☐	☐
Penicillin or other Antiobiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates, Sedatives, Sleeping Pills	☐	☐
Aspirin, Acetaminophen, Ibruprofen	☐	☐
Codein, Demerol, or other Narcotics	☐	☐
Reaction to Metals (Rings, Jewelry)	☐	☐
Latex	☐	☐
Other	☐	☐

Explain _____

During the past 12 months, have you taken any of the following?

	YES	NO
Antiobiotics or Sulfa Drugs	☐	☐
Anticoagulants (e.g. Coumadin)	☐	☐
High Blood Pressure Medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or Similar Drug	☐	☐
Aspirin	☐	☐
Digitalis or Drugs for Heart Trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (Steriods)	☐	☐
Natural Remedies	☐	☐
Nonprescription Drug/Supplements	☐	☐
Other	☐	☐

Explain _____

Signed _____ Date: _____

(Patient or Parent, if minor)

Personalized Dental Healthcare